National American Indian & Alaska Native
PTTC Prevention Technology Transfer Center Network
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Prevention

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Early Intervention & Secondary Prevention

National American Indian & Alaska Native Prevention Technology Transfer Center
145 North Riverside Drive, Iowa City Iowa 52245
pttcnetwork.org/native

DIRECTOR'S CORNER

Welcome to our first issue of the newsletter for the National American Indian and Alaska Native Prevention Technology Transfer Center (National AI/AN PTTC). We chose to focus this issue on early intervention, because we want to acknowledge the importance of detecting addiction or any behavioral health issue early. Early intervention can change the course of a behavioral health disorder dramatically. Many tribal communities have developed routines for evaluating possible behavioral health disorders when a client visits an Indian Health Clinic or another health facility in the tribe (638 programs). Therefore, we chose to interview James Ward, MBA, about how he, together with a tribal community in Southern California, have solved this problem. You will find his interview on page 10.

In addition to this first newsletter, we offer monthly webinars on important topics on prevention in tribal and urban Indian communities. Furthermore, this PTTC has initiated several other projects. Early on and before we were awarded this grant, we discovered that the culture card called "A Guide to Build Cultural Awareness," developed by SAMHSA in 2010, is very popular and used a lot by prevention specialists. We decided to start the process of developing several similar cards with the emphasis on American Indian and Alaska Native issues in prevention. The name of the culture card series is *Connecting Prevention Specialists to Native Communities,* with the first titled, *Culture is Prevention,* and the second, *Cultural Connectedness.* These will be made available on our website.

We will soon pilot a training-of-trainers program for Native prevention specialists across the country and our intent is to increase prevention capacity at the local level. We also would like to provide tribal communities with technical assistance in implementing prevention programs in their own communities. This project is a collaboration between our National American Indian and Alaska Native Prevention, Addiction, and Mental Health K-12 Supplement TTCs. We have already started with a webinar on models for prevention by Paul Gilbert, and another will follow shortly by Shelly Campo, both faculty members in our centers and The University of Iowa Department of Community and Behavioral Health. After these two introductory webinars we will solicit community prevention specialists who would like to work with us on developing prevention programs in their communities.

Furthermore, our center has initiated collaborations with various partners in the field including collaboration with the Indian Country Child Trauma Center on Secondary Prevention and Trauma-Informed Care, in the Honoring Children, Mending the Circle training. This collaboration will be kicked off with a training event in September in Oklahoma City.

We often see a great turn-over in leadership in tribal and urban Indian communities. However, consistent leadership is important in developing a systematic behavioral health prevention plan in the same communities. Accordingly, we are in the process of soliciting applications to our American Indian and Alaska Native Leadership Academy, and we are looking for mentors in particular. It is often difficult in tribal communities to differentiate between what is primary, secondary, and tertiary prevention and behavioral health specialists often need to be a "jack-of-all-trades," in order to be effective. They also need to be able to collaborate with providers from different agencies and the Tribal Council and base their program development on principals of Community-Based-Participatory-Programming (CBPP/R). Therefore, we have decided to offer the Leadership Academy as a collaboration across our three programs in prevention, addiction, and mental health. This collaboration we hope will facilitate networking between mentees and mentors and enhance the likelihood of tribal communities being able to implement prevention program systematically and sustainably.

Finally, I would like to introduce our Program Coordinator for the National American Indian and Alaska Native PTTC, Cindy Sagoe, MPH. Cindy is a pharmacist and member of the Akan tribe in Ghana, and she and I are very excited about working with Native prevention specialists across the country, and we really want to hear from you about your specific challenges and success stories, or any specific areas where you might like training or technical assistance.

We look forward to working with you,

Anne Helene Skinstad, PhD

Addressing Behavioral and Mental Health Disorders at the Primary Care Level

Using the Screening, Brief Intervention and Referral to Treatment (SBIRT) Model

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KEN C. WINTERS, PhD
***contributions from* MARY K. WINTERS, MEd**

Significance of the SBIRT Model

Prevention and early intervention are critical strategies for reducing mental and behavioral problems (MBPs). With the growing percentage of individuals seeing a primary care provider yearly, primary care settings and professionals are uniquely positioned to provide an opportunity for people to have a private conversation and a teachable moment about sensitive health topics with a trusted health care professional. Many people consider physicians an authoritative source of knowledge about more than so-called "physical" health and are receptive to discussing personal problems[1].

Over the past decade, there has been growing interest and research in a comprehensive, integrated public health approach called Screening, Brief Intervention, and Referral to Treatment (SBIRT) as a means of delivering early intervention and treatment services to address MBPs[10]. By using rapid screening and assessment tools, clinicians can quickly screen (S) for possible MBPs, provide an immediate and brief intervention (BI), and determine need for follow-up or referral to treatment or other additional services (RT). The application of the SBIRT model for substance use problems has received the most attention in the research literature. But there is growing recognition that major investments to expand SBIRT in primary care settings to address MBPs will yield significant public health benefits.

Despite the promise of SBIRT, there are realistic barriers to implementing this model in a primary care setting. Frequently cited barriers are lack of time, insufficient training, and lack of familiarity with standardized tools and brief interventions[11]. Most clients receiving health services in primary care settings will not request help for MBPs. Yet these barriers are not insurmountable. Utilizing a screening tool or tools and inquiring about lifestyle choices, such as substance use, tobacco, etc., may help identify whether emotional concerns are contributing to current health concerns. The screening process can be easy to administer and within reason, accurately inform the clinician as to the client's level of risk. With the advent of clinical-friendly motivational interviewing techniques, relatively simple, brief and practical interventions can be readily learned and effectively implemented by a broad of range of service providers. Existing protocols for referring clients for additional treatment and other services can be refined to fit an SBIRT model. In this column, we describe the SBIRT framework and its application during primary care health visits. We also address the importance of adapting the components of this model for American Indian and Alaska Native (AI/AN) clients.

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Screening

There are two primary goals of screening with the SBIRT model. One goal is to identify an individual whose current emotional distress or behavior problem suggests that they are at high risk for developing a serious mental or behavioral disorder. The level of current problems is likely to be at the mild or moderate level, and if not addressed, may escalate to a more serious problem. An example would be a person who is a daily or near daily heavy drinker; continued use of this drinking pattern puts this person at high risk for developing an alcohol use disorder. The other general goal of screening is to identify signs or symptoms that suggest a current serious disorder is severely affecting the client's daily functioning (e.g., major depression) or that indicates the client is in a crisis situation (e.g., victim of physical abuse). In all instances, the outcomes of the screening can lead to an appropriate clinical intervention ranging from a discussion about taking steps toward a healthier lifestyle to a referral to a treatment program.

Using a validated developmentally appropriate screening tool is critical to accurate assessment of the target problem. Why is this important? Research suggests that even experienced health care providers often underestimate the extent of "personal" problems in a client when relying on clinical impressions alone[6]. Yet as we will discuss in a subsequent section, there are two cautions with the use of standardized tools with Native clients: (1) many are not developed and validated with AI/AN individuals, which calls into question their relevance for this population, and (2) the background of an individual may lead some self-reported experiences to be falsely labeled as a clinical problem.

Nonetheless, it is the recommendation by many professional organizations to screen for MBPs at health maintenance visits. There may be a perception that such visits do not produce client disclosures of problems (or referred to as a "positive screen"). It is the case that positive screens for problematic behavior are higher among patients presenting for urgent care and follow-up visits compared to health maintenance visits[3]. But well-visits are also an opportunistic screening setting to identify individuals who are willing to disclose MBPs.

Screening can be done face-to-face between provider and patient or via self-administered screens (computer or paper). There is research supporting the view that most patients prefer self-administered screens and that this method yields greater honesty, even with the knowledge that their provider will have access to the results[7]. There are two other advantages of the self-administered format: (1) administration prior to the appointment adds an additional benefit of more time available during the visit for a focused discussion between the provider and patient, and (2) a review of results from the screening serves as a comfortable opening to the initial interview with the client. Whatever the route of administration, clients should be assured of confidentiality (within the limits of a mandated reporter), which most certainly improves the extent and accuracy of disclosing personal problems.

What to screen?

There are numerous considerations that pertain to this complex issue. One principle is to screen for MBPs based on what the research literature indicates are clinical problems with a relatively high prevalence rate in the general population. Also relevant are issues within a Native population that may not be informed by national surveys. A list of candidate topic areas for screening are the following: alcohol use, tobacco use, illicit substance use, depression, anxiety, exposure to trauma, victimization of abuse, and recent and significant changes in behavior (e.g., change in sleep) or one's life situation (e.g., job change; change in an inter-personal relationship).

Another screening consideration is that the breadth of screening may be dictated on how much time is available for the screening process. The more time to conduct a screening, the more content areas that can be screened. It is this author's view that a screening battery that can screen for a core group of MBPs will take at least 15 minutes.

A final issue is that the results of screening may show several positive screens and this may "overwhelm" the service provider. This issue can deter health clinics from engaging in the MBP screening process. Even a brief conversation about the client's problems can be of value to a client. We will address this issue in more depth in the section below on Brief Interventions.

Screening tools

Good screening tools are those that consist of the fewest number of validated questions that can elicit accurate and reliable responses. There are several validated screening tools to address a range of MBPs. Readers are encouraged to visit a recent resource developed by the National Institute on Health, the PhenX Toolkit *(www.phenxtookit.org)*. This is a web-based catalog that includes high-priority measures for BMPs. Work groups of experts selected the measures. Presented below in Table 1 are three well-known screening tools for select problem areas.

Table 1

Problem Area	Tool	Length
Substance abuse	Drug abuse screening test	10 items
General mental health	General well being schedule	18 items
Quality of life	Quality of life enjoyment and satisfaction questionnaire - short form	16 items

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Brief Intervention (BI)

Based on the results from the screening, it is advisable to follow with a brief counseling experience, which can range from a brief conversation (e.g., 10 minutes) to a few counseling sessions. Commonly referred to as a brief intervention (BI), the focus is to encourage patients to make healthy choices and prevent, reduce, or stop risky behaviors. Other features are to offer praise and encouragement for client intent to make changes, promote client strengths, and negotiate a clear path forward in terms of goals. BIs commonly employ Motivational Interviewing (MI) techniques. MI skills include asking open-ended questions, affirming the concerns of the client, being a reflective listener and providing summary statements. Core features also include rolling with resistance (moving onto another topic; suggesting a different perspective), expressing empathy (understanding the client's perspective), and supporting self-efficacy (instilling faith that the client can make changes)[8].

Intensity of Brief Interventions

The length of a BI can vary from a few counseling sessions to a very brief conversation. We describe below three examples based on length. Which type to use can depend on the time and resources available to the service provider, the results of the screening tool, and counselor experience.

1. **"Brief" (two 60-minute sessions)**
   - Screen the client for a select range of MBPs (e.g., drug abuse, general mental health).
   - Conduct two separate 60-minute counseling sessions, with approximately 7-10 days between sessions. Utilizing an MI approach, focus the sessions on the two or three MBPs identified by the screening process that are most contributing to impairment in the client's daily functioning.
   - At the end of the second session, (1) provide fact sheets; (2) consider and discuss with the client having a booster session in a few weeks (to review continued progress; address barriers; expand goals); and (3) consider and discuss with the client a referral to an internal or external provider for additional treatment or other health-related services.
2. **"Briefer" (single 60-minute session)**
   - Screen the client for a select range of MBPs (e.g., drug abuse, general mental health).
   - Conduct a single 60-minute counseling session. Utilizing an MI interviewing approach, focus the session on the MBP identified by the screening process contributing the most to impairment in the client's daily functioning.
   - At the end of the session, (1) provide fact sheets; and (2) consider and discuss with the client a referral to an internal or external provider for additional treatment or other health-related services.
3. **"Briefest" (10-15 minutes)**
   - Screen the client for a select range of MBPs (e.g., drug abuse, general mental health).
   - Conduct a single 10-15 minute conversation. Utilizing an MI approach, focus the conversation on the results of the screening process.
   - At the end of the conversation, (1) provide fact sheets; and (2) consider and discuss with the client a referral to an internal or external provider for additional treatment or other health-related services.

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Personalizing the Brief Intervention

The BI model proposed here argues for the value of personalizing the focus of the counseling on the problem or problems that are significantly affecting the person. In this light, the counselor has to take a personalized approach when conducting a BI. The goal of a personalized behavior change program is to base the counseling decisions on the unique profile of each individual. By directing the behavioral change discussion to address the client's salient problem or problems, intervention effectiveness is likely to be optimized (Kazdin & Nook, 2003). In the table below we consider four problem areas (substance abuse, stress, depression, trauma) and provide descriptors of the personalized intervention goals and counseling strategies. The table is most relevant when utilizing either the "brief" (two sessions) or "briefer" (one session) version of a BI.

Table 2

Problem Area	Intervention Goals	Counseling Activity/Strategy
Substance abuse	Increase problem recognition that substance use is harmful; identify triggers of use; enhance belief in self-efficacy	Engagement; decisional balance; strategies to address triggers of substance use; set goals for abstinence or risk reduction
Stress	Recognize warning signs of stress; identify sources of stress; recognize sources that can and cannot be changed; increase skills and self-efficacy to reduce stress	Engagement; cognitive restructuring to change stress appraisal; training in assertive communication skills; planning to increase pleasant activities; and training in exercises to control stress arousal (e.g., deep breathing; mindfulness); setting goals
Depression	Recognize symptoms and sources of depression; recognize sources that can and cannot be changed; increase skills and self-efficacy to address depressed mood	Engagement; cognitive behavioral strategies to improve self- image; training in positive mood strategies (e.g., cognitive restructuring; social skills); planning to increase pleasant activities; emphasize the importance of seeking support from others; setting goals
Dealing with trauma	Acknowledge and process trauma-related memories; recognize the need to release any pent up 'fight-or-flight' energy; learn how to regulate strong emotions; learn to trust others again	Engagement; cognitive behavioral strategies to process and evaluate thoughts and feelings about the trauma, and to improve self-image; training in strategies to reduce negative emotions related to the trauma (e.g., cognitive restructuring); planning to increase pleasant activities; emphasize the importance of seeking support from others; setting goals

Referral to Treatment

Many clients need a referral for more specialized services after the screening and BI. The counselor may conclude that the client's problems are severe enough to warrant more treatment. The counselor should employ MI strategies to encourage the client to voluntarily agree to additional services; it is likely that a client who voluntarily accepts a referral to treatment is more likely to engage in that care.

There are many barriers that impede referrals, including limited insurance coverage, lack of programs or specialists by geographic location, lack of access and distance to Indian Health Services and/or tribal treatment programs, as well as lack of engagement by the client. It is advisable that any referral for additional services include a detailed assessment by a specialist to determine level and type of care (e.g., short or long term treatment; individual or group counseling; outpatient or inpatient, medically-managed treatment). Also, providers should develop relationships with internal services within one's health setting or with external resources in their geographical location, including community mental health centers, and follow up with the program and client after referral. There are national resource guides through the Substance Abuse and Mental Health Services Administration (SAMHSA) to help identify options throughout the country (*https://www.samhsa.gov/find-treatment*).

Implementation Issues

Culture influences every aspect of health care, and this is certainly the case when implementing an SBIRT program. From the client perspective, culture shapes how they describe the problems, pattern of symptoms, and experiences of distress. Culture also influences the client's perceptions of the type of health care received and the recommendation by the service provider as a course of action. The models and approaches used by a clinic and the service provider are also influenced by culture. *When there is harmony among the client, health clinic and service provider in terms of cultural perspectives, the likelihood of a favorable health outcome for the client is increased.* But misunderstandings, biases, and communication gaps between providers and patients resulting from cultural factors will likely erode the client-service provider relationship and create health care disparities.

Even when a client and service provider share similar cultural backgrounds, negative therapeutic influences can occur via differences in gender, age, and sexual orientation, for example. On the other hand, just because a service provider and client do not share culture or identity characteristics, a strong and healthy therapeutic alliance can be forged.

We recognize that successful interventions can be difficult to achieve within AI/AN communities. The complicated history of Native communities with external health systems, challenges with state and federal policies, and the mistrust of collaborations that have a top-down, hierarchical approach are significant sources that limit program development and implementation[2]. Rather, a community-based initiative organized around a participatory, non-hierarchal approach that views health problems and solutions through a cultural lens is optimal. Elements of such a method include honoring the knowledge of community members, investing human and financial resources in building trustworthy relationships between service providers and community leaders, and blending research-based clinical knowledge with community-generated knowledge-based and experience-based solutions. This methodology is grounded in a partnership mentality, and can promote the group's objectives to create a shared vision of proactive, preventive healthcare among all partners, produce mission and vision statements, identify core values, and clarify the clinical services and prevention practices that meet community standards and best practices for health.

This newsletter includes a description of a model program under the leadership of James Ward, MBA, to advance best practices in screening AI/AN youth for behavioral health problems at the primary care level. James is an enrolled tribal member of the Choctaw Nation of Oklahoma, the president and CEO of J.L. Ward Associates, Inc., a consulting firm that specializes in Indian health care planning, development, and evaluation. He is the lead consultant on the California Area Indian Health Service (CAIHS) Youth Regional Treatment Center (YRTC) aftercare evidence-based practice project which has developed a best practice, culturally informed program that has evolved to be a transformative program for primary care clinics and the clients they serve. YRTC provides a roadmap for how to move the SBIRT model from "bench to trench" within the AI/AN health care system.

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Summary

Mental and behavioral problems (MBPs) often go undetected during primary health care visits. Screening for MBPs with evidence-based tools can identify clients who may benefit from a brief intervention. Brief interventions, which can vary in intensity, aim to initiate behavior change in the person and may help the client to seek additional services, if needed. The effectiveness of an SBIRT program in an AI/AN health care system will be optimized if it is shaped by input from the community and is culturally adapted.

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"[We screen everyone] because you never know when you're going to hit somebody that has problems."

- Screening Participant A

Screening in Tribal and Urban Indian Health Programs

NATASHA PETERSON, BS
Program Manager, Mental Health TTC Supplement

James Ward, MBA, is an enrolled tribal member of the Choctaw Nation of Oklahoma, who currently lives on the Barona Indian Reservation in California where his wife is an enrolled tribal member. Mr. Ward and his company, J.L. Ward Associates, Inc., have spent the last 25 years working with tribal, federal, and urban Indian health programs. During that time, the company has helped these programs obtain over $100 million in federal and state funding. They have provided consulting to the California Area Office of the Indian Health Service (IHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the US Assistance Secretary for Planning and Evaluation (ASPE), and universities with American Indian and Alaska Native health institutions.

Last year, J.L. Ward Associates, Inc. evaluated the behavioral health service resources and methods of 38 of the 39 tribal and urban Indian health programs in California for the IHS. Following this evaluation, a report was written entitled, *Behavioral Health Screening in Primary Care Settings 2016.* Excerpts from the report include:

> *In FY 2007, the Indian Health Service (IHS) initiated a study of qualitative and quantitative data to identify and analyze factors contributing to high-quality behavioral health preventive care screening, as measured by performance on selected GPRA* measures. The study team, which included staff from the Division of Planning, Evaluation, and Research (DPER) and the IHS National GPRA Support Team (NGST), selected three GPRA behavioral health screening measures to analyze: Depression Screening, Alcohol Screening, and Domestic/Intimate Partner Violence Screening.*
>
> *This study identified practices that contribute to higher rates of behavioral health screening among higher performing clinics. The best practices found at all higher performing sites included Universal Screening, Staff Core Competency, and Coordination of Care. All higher performing sites made behavioral health screenings a high priority within their primary care clinics.*

The full report can be found here:
https://www.ihs.gov/dper/includes/themes/responsive2017/display_objects/documents/evaluation/IHSEvaluationofBehavioralHealthScreeningMeasures.pdf

In congruence with this evaluation, and based off their many years of experience working to address problems and barriers in the identification and treatment of mental health issues in Indian health programs, J.L. Ward Associates, Inc. designed and developed ScreenDox in 2016. This software application is designed for Indian health programs to electronically screen their patients in their medical departments for behavioral health problems including: tobacco exposure, tobacco use, alcohol use, drug use, depression, suicide ideation, and domestic/intimate partner violence.

Over the last few years, ScreenDox has been tested and implemented at Riverside-San Bernardino County Indian Health – the largest tribal health organization in California. During this time, they have completed over 40,000 behavioral health screens for over 13,000 individual patients.

For an overview of J.L. Ward Associates' program, ScreenDox and their work with screening and early intervention of both Native youth and adults, please explore their websites below:

https://www.jlwardassociates.com/

https://screendox.com/

You may contact James Ward at
james@jlwardassociates.com

**GPRA stands for the Government Performance and Results Modernization Act of 2010, which updated some aspects of the Government Performance and Results Act (GPRA) of 1993. Federal agencies are required to set long-term goals and objectives as well as specific near-term performance goals. As part of this federal mandate, all SAMHSA grantees are required to collect and report performance data using approved measurement tools.*

"…domestic violence, or alcohol, or even all three screenings…it is a respecter of no person or status. It doesn't matter if you have a diamond necklace or if you have an old ragged t-shirt, you're going to get screened."

- Screening Participant B

From left: Joseph Pruitt, OD; Steev Yovan; Yvonne Luna, CPC; James Ward, MBA; Cynthia Nakoski, PsyD; Ramon Ferra, MD; Aidan Clarke, MD; Herbert McMichael, PhD; and Jeevan Dhouni, RPh, PharmD

The Interconnected Cycle of Life:

From teacher to student, parent to child:

I did not give you Life; your life had already been predetermined.

My role was to prepare you for Life's challenges; as your experiences had already been preconceived.

As I awaited the education that you needed, I also awaited your recognition that you needed what I was prepared to give you.

Ultimately, I can only teach you what you are capable and ready to listen to; the rest is up to you to see the relevance and need for learning of the years of knowledge freely given to you.

Where Our Roads Converge

With every person, place, time, or occasion, each was predestined before we were ever born. The Mysteries lay within each encounter, yet each decision we make decides the darkness or the brightness with each occasion. Knowledge is partaken in how we perceive them, as well as how hungry we are at the moment.

The words and actions we choose can leave an everlasting mark upon those to whom they are directed, yet they also affect those who are present.

Let not your mouth nor deeds harm another, only for the gratification of thought.

Sean A. Bear I
Co Director, Meskwaki Tribal Member

Newsletter Editorial Board and Contributors

SAMHSA
Substance Abuse and Mental Health Services Administration

The American Indian & Alaska Native Leadership Academy

Accepting applications for mentors through May 31!

Find applications and additional information on our website:
https://attcnetwork.org/native

or contact Monica Dreyer Rossi:
monica-dreyerrossi@uiowa.edu